proportionate share of the aggregate losses for all general hospitals within such category, provided however, that the amount reserved within a category shall not exceed the aggregate amount of losses within such category.

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Section 86-1.74 Supplementary Bad Debt and Charity Care Disproportionate Share Adjustment. (a) The rates of payment made to major public hospitals as defined in section 86-1.65(b) of this Subpart for the periods July 1, 1989 through December 31, 1989, and January 1, 1990 through December 31, 1990, for a person eligible for payments made by State governmental agencies applicable to patients eligible for medical assistance pursuant to Title 11 of Article 5 of the Social Services Law shall include a supplementary bad debt and charity care adjustment determined in accordance with subdivision (b) of this section. Rates of payment to such major public hospitals for rate years commencing January 1, 1991 and [~~thereafter~~] **prior to January 1, 1997** for persons eligible for federal financial participation under Title XIX of the federal Social Security Act in medical assistance paid by State governmental agencies pursuant to Title 11 of Article 5 of the Social Services Law, shall include a supplementary bad debt and charity care adjustment determined in accordance with subdivision (b) of this section. Such adjustments shall be made provided the State governmental agency or the government of the county in which the hospital is located or the city of New York for a general hospital operated by the New York City Health and Hospitals Corporation files with the Commissioner in writing an election for such adjustment by September 1, 1989 for the period July 1, 1989 through December 31, 1989, by October 15, 1989 for the period January 1, 1990 through December 31, 1990, and by October 15 of the rate year preceding the rate year for rate years commencing January 1, 1991 and thereafter for such hospital for each period. Such election is subject to the approval of the State Director of the Budget and contingent upon all federal approvals necessary by federal law and rules for federal financial participation for medical assistance under Title XIX of the federal Social Security Act based upon the adjustment provided herein as a component of such payments being granted.

(b) The supplementary bad debt and charity care adjustment shall be determined for the period July 1, 1989 through December 31, 1989 based on historical data collected for the period April 1, 1989 through December 31, 1989 and for the period January 1 through December 31 for each subsequent rate period based on the amount calculated by subtracting the amount projected to be distributed to such major public hospitals pursuant to section 86-1.65(d) of this Subpart for such period from an amount calculated as the product of the projected bad debt and charity care nominal

payment amount coverage ratio for such period for voluntary sector hospitals as defined in section 86-1.65(b) of this Subpart multiplied by the base

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86-1.75 Estimate of real non-Medicare **and Medicaid** cumulative case mix increase. (a) For purposes of the computation pursuant to section 86-1.60(b) for historical rate years commencing January 1, 1994 and ending **December 31, 1996** an estimated real non-Medicare cumulative case mix increase, [~~and~~] an estimated non-Medicare cumulative case mix increase to be attributable to changes in coding practices, and for rate years commencing January 1, 1997 and thereafter an **estimated real Medicaid cumulative case mix increase and an estimated Medicaid cumulative case mix increase to be attributable to changes in coding practices** shall be determined based on those [~~non-Medicare~~] discharges for which the hospital has submitted Discharge Data Abstracts (DDAs) for 1992 and universal data sets (UDSs) for each rate year beginning January 1, 1994, submitted no later than April 30 of the following rate year to the Statewide Planning and Research Cooperative System (SPARCS). Case mix changes due to acquired immune deficiency syndrome, tuberculosis, epidemics and other catastrophes resulting in extraordinary hospital utilization shall be exempted from the provisions of this section.

(b) The case mix indices used in estimating the reported non-Medicare case mix increase, the estimated real non-Medicare case mix increase, [~~and~~] the non-Medicare case mix increase estimated to be attributable to changes in coding practices, **the reported Medicaid case mix increase, the estimated real Medicaid case mix increase and the Medicaid case mix increase estimated to be attributable to changes in coding practices** pursuant to subdivisions (c), (d) and (e), respectively, of this section shall be as follows:

(1) A reported base year case mix index for each hospital shall be determined based on those 1992 non-Medicare DDA discharges **and 1996 Medicaid UDS discharges**, hereafter referred to as base year discharges, for which the hospital has submitted DDAs **and UDSs** pursuant to subdivision (a) of this section and such discharges that would not be exempt from the case payment reimbursement system.

(2) A statewide reported base year case mix index shall be determined by multiplying the base year case mix index for each hospital determined pursuant to paragraph (1) of this subdivision by the base year discharges

and dividing the statewide sum of the results by the sum of the base year discharges.

(3) A reported rate year case mix index for each hospital shall be determined based on those rate year discharges, hereafter referred to as rate year discharges, for which the hospital has submitted DDAs and UDSs pursuant to subdivision (a) of this section and such discharges that would not be exempt from the case payment reimbursement system.

(4) A statewide reported rate year case mix index shall be determined by multiplying the rate year case mix index for each hospital determined pursuant to paragraph (3) of this subdivision by the rate year discharges and dividing the sum of the results by the statewide sum of the rate year discharges.

(5) Estimated real base and rate year case mix indices for each hospital shall be determined based on the following:

(i) discharges which are classified into DRGs that are split on the presence of complication and/or comorbidity which, because of their nature are more susceptible to changes in coding practices, shall

have SIW values assigned to those DRGs in the base year to reflect the same proportion of cases split on the presence of a complication and/or comorbidity in the rate year.

(11) Discharges in the rate year that have been coded more accurately due to the incentives in the case payment system and/or with new codes necessitated by changes in the New York State grouper which did not previously exist in the base year shall be treated consistently in each year with respect to DRG assignment.

(6) Estimated real statewide base year and rate year case mix indices shall be determined based upon the hospital-specific estimated real base and rate year case mix indices determined pursuant to paragraph (5) of this subdivision except:

(i) if the estimated [~~non-Medicare~~] case mix increase to be attributable to changes in coding practices determined pursuant to subdivision (e) of this section for a hospital is equal to zero, the reported base year and rate year case mix indices for the hospital shall be used in the determination of the estimated real statewide base year and rate year case mix indices; or

(ii) if the estimated [~~non-Medicare~~] case mix increase to be attributable to changes in coding practices determined pursuant to subdivision (e) of this section for any hospital is greater than zero, the hospital's estimated real base year and rate year case mix indices as determined pursuant to paragraph (5) of this subdivision shall be modified to reflect the adjustments made pursuant to paragraph (2) of

subdivision (e) of this section and be used in the determination of the estimated real statewide base year and rate year case mix indices.

(c) The reported [~~non-Medicare~~] case mix increase for each hospital shall be determined by subtracting 1 from the result of dividing the reported rate year case mix index determined pursuant to paragraph (3) of subdivision (b) of this section by the reported base year case mix index determined pursuant to paragraph (1) of subdivision (b) of this section.

(d) The estimated real [~~non-Medicare~~] case mix increase for each hospital shall be determined by subtracting 1 from the result of dividing the estimated real rate year case mix index determined pursuant to paragraph (5) of subdivision (b) of this section by the estimated real base year case mix index determined pursuant to paragraph (5) of subdivision (b) of this section.

(e) The estimated [~~non-Medicare~~] case mix increase estimated to be attributable to changes in coding practices for each facility shall be:

(1) zero for those facilities where the result of subtracting the estimated real [~~non-Medicare~~] case mix increase determined pursuant to subdivision (d) of this section from the reported [~~non-Medicare~~] case mix increase determined pursuant to subdivision (c) of this section is less than .005.

(2) for all other hospitals, the greater of .005 or one-half of the difference between the estimated real non-Medicare case mix increase and the reported non-Medicare case mix increase, and the difference between the estimated real Medicaid case mix increase and the reported Medicaid case mix increase, with a maximum of .02 shall

be subtracted from the result of subtracting the estimated real [~~non-Medicare~~] case mix increase determined pursuant to subdivision (d) of this section from the reported [~~non-Medicare~~] case mix increase determined pursuant to subdivision (c) of this section.

(f) An adjusted real [~~non-Medicare~~] case mix increase shall be the reported [~~non-Medicare~~] case mix increase determined pursuant to subdivision (c) of this section less the estimated [~~non-Medicare~~] case mix increase estimated to be attributable to coding practices determined pursuant to subdivision (e) of this section.

(g) The case mix indices determined pursuant to this section shall be the result of dividing the sum of weighted discharges by the sum of actual discharges where weighted discharges shall be determined as follows:

(1) the weighted discharge for an inlier case shall be the corresponding SIW determined pursuant to section 86-1.62 of this Subpart.

(2) the weighted discharge for a short stay discharge shall be the result of multiplying the number of days for that case by the short stay weighting factor of 1.5 and the SIW determined pursuant to section 86-1.62 of this Subpart and dividing the result by the average length of stay for the DRG determined pursuant to section 86-1.62 of this Subpart.

(3) the weighted discharge for a transfer discharge shall be the result of multiplying the number of days for that case by the transfer weighting factor of 1.2 and the SIW determined pursuant to section 86-1.62 of this Subpart and dividing the result by the average length of stay for the DRG determined pursuant to section 86-1.62 of this Subpart.

~~[(d) Any portion not allocated in accordance with subdivision (a) through (c) of this section shall be reallocated to further fund the adjustments specified in clauses (c) and (d) of section 86 1.52(a)(1)(iv) and subdivision (c) of this section in the same proportion as their original funding.~~]

New York
249(b)

(1/97)
Attachment 4.19-A
Part I

86-1.90 Effective January 1, 1997, rates of payment for general hospital inpatient services shall be increased by 5.98 percent to reimburse an assessment on net Medicaid patient service revenues.

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New York
249(c)

86-1.91 (3/97)
Attachment 4.19-A
Part I

86-1.91 Public general hospital indigent care adjustment. For rate periods commencing January 1, 1997 and thereafter, each eligible public general hospital shall receive an annual amount equal to the amount allocated to such public general hospitals as determined pursuant to sections 86-1.74 and 86-1.84 of this Subpart for the period January 1, 1996 through December 31, 1996. The adjustment may be made to rates of payment or as aggregate payments to an eligible public general hospital and is contingent upon all federal approvals necessary by federal law and rules for federal financial participation for medical assistance under Title XIX of the federal Social Security Act based upon the adjustment provided herein as a component of such payments being granted.

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